choice instrument to elicit women's tradeoff preferences for various treatment attributes, including both benefits and risks for therapies to relieve vasomotor symptoms. The survey was administered to 500 US women between the ages of 46 and 60, randomly sampled from a large internet consumer panel. Two survey versions were administered to split samples. The versions were identical except that risk descriptions incorporated relative risks in one version and absolute risks in the other version. Ordered-probit importance weights for various health states and risks were estimated from the resulting tradeoff data. **RESULTS:** We found that the risk description did not affect ordered-probit estimates of respondents' preferences for risk of fracture and heart attack, but did affect preferences for the risk of breast cancer. Subjects who received the relative-risk versions indicated that a decrease in risk of breast cancer from 3.9% to 2.3% was 64% more important than subjects who received the absolute-risk version. Conversely, subjects who received the absolute-risk version were more concerned about relieving vasomotor symptoms. Relieving the severity of hot flashes was 44% more important, reducing the frequency of hot flashes was 40% more important, and reducing the frequency of night sweats was 50% more important for subjects who received the absolute-risk version than for subjects who received the relative risk version. **CONCLUSION:** Although health professionals presumably interpret clinical relative-risk results in the context of the base prevalence of a condition, laypersons often do not have access to base-rate information. Our results suggest that more careful characterization of adverse-event risks is important in helping women make fully informed choices among alternative treatments for vasomotor symptoms.

QL2

NEW WEIGHTS FOR OLD: A SCALE OF VALUES FOR EQ-5D HEALTH STATES

Kind P, Macran S, Hennessy S
University of York, York, UK

OBJECTIVES: EQ-5D is one of the most widely used index measures of health-related quality of life. Ten years have passed since the first UK national survey that established preference weights for EQ-5D health states. That protocol elicited values for 45 of the 245 possible EQ-5D health states. Values for the remaining health states were interpolated from estimation models based on the values for directly observed states. The process of model construction and testing was onerous and labour intensive. Estimated values remained largely untested as replication studies are virtually non-existent. This paper reports on an alternative approach in which values for *ALL* health states are elicited. **METHODS:** The standard questionnaire used to value EQ-5D health states records VAS ratings on a 0–100 scale, for 16 health states presented as two groups of eight on consecutive pages. The logically best and worst health states are repeated on each page. A value for dead is also elicited in each questionnaire. For this study, 21 versions of the questionnaire were designed, each presenting 14 different states. Questionnaires were mailed to 1100 individuals selected randomly from the electoral registers of England and Wales. **RESULTS:** A response rate of 62% was achieved (n = 685). Mean VAS scores from this survey were similar to those elicited ten years earlier although the value for dead was 45% higher than its predecessor. A smooth, well-behaved set of values for all 245 states was derived using OLS regression ($r2 = 0.974$, $p < 0.001$). Transformed to a 0–1 scale, values were systematically higher than the corresponding TTO weights used as standard in NICE appraisals reporting EQ-5D. Only 12 states demonstrate negative values. **CONCLUSIONS:** Traditional interview-based procedures are costly. This study demonstrates the feasibility of postal survey methods and simultaneously poses a dilemma for end-users. Are contemporary VAS–based values preferable to decade old TTO-based values?

QL3

(For QL3 see page 337)

QL4

THE CONTENT VALIDITY OF CLINICIAN DERIVED PATIENT REPORTED OUTCOMES (PRO) MEASURES: THE ROLAND MORRIS DISABILITY QUESTIONNAIRE

Horowicz-Mehler N[1], Evans CJ[1], Abetz L[2], West C[3], Copley-Merriman K[3]
[1]Mapi Values, Boston, MA, USA; [2]Mapi Values, Cheshire, UK; [3]Pfizer Inc, Ann Arbor, MI, USA

OBJECTIVES: The FDA currently requires patient interviews in the process of developing a new PRO measure. In the past, many questionnaires were developed based solely on clinician expertise and patient involvement in the creation of items was non-existent. In order to ensure existing questionnaires are accepted by the FDA, it is necessary to confirm the content validity of